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IN THE
Supreme Court of the United States

October Term, 1971
No. 70-40

MARY DOE, et al., etc.,

Appellants,

vs.

**ARTHUR K. BOLTON, Attorney General of the State of
Georgia, et al., etc.,**

Appellees.

On Appeal From the United States District Court for the
Northern District of Georgia.

**Motion for Leave to File Brief Amici Curiae
in Support of Appellants.**

The National Legal Program on Health Problems of the Poor, the National Welfare Rights Organization and the American Public Health Association hereby respectfully move the Court for leave to file their attached brief *amici curiae* in support of appellants in the above-entitled matter.

The National Legal Program on Health Problems of the Poor is a law reform center funded by the U.S. Office of Economic Opportunity to provide support for OEO Legal Services programs across the country in

cases involving health problems of the poor, and to provide, through education, research and legal representation, assistance in the preparation of important litigation in health law. In that capacity, the Program participated as *amicus curiae* in this case in the court below. The Program is based at UCLA School of Law.

The National Welfare Rights Organization is a voluntary association with 125,000 members in 50 states, organized to represent the interests of low income people and welfare recipients with regard to redress of legal grievances, to act as a spokesman for such people and to educate and inform them of their legal rights.

The American Public Health Association is a voluntary association of professionals and others in the field of health care who are concerned about improving the quality and the means of providing for the health care of the American people. The APHA works to identify and study these problems, and to communicate its concerns to the government and the public.

These organizations share the view that restrictive state abortion laws, such as the Georgia statute here under review, have a negative effect on the health and well-being of American women, and have a particularly severe impact on the nation's poor and non-white populations. It is the poor and non-white who suffer most from limited access to legal abortion, and it is they who incur greatly disproportionate numbers of deaths and crippling injuries as a result of being forced to seek criminal abortion.

There are a number of grounds for constitutional challenge to the abortion law here under review. *Amici* request leave to file this brief at the invitation of counsel for appellants, in order to present in some depth the argument that the discriminatory application and effect of the abortion law denies to the poor and non-white the equal protection of the law.

It is the understanding and belief of *amici* that this argument will not be developed in any detail in the principal briefs for appellants, and that appellants rely on the within brief for this purpose. Therefore, the equal protection analysis and issues raised in this brief will not be repetitious of other arguments.

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BRIEF OF AMICI CURIAE.

Summary of Argument.

A woman who seeks an abortion is asserting certain fundamental rights which are protected by the Constitution. Among these are the rights to marital and family privacy, to individual and sexual privacy; in sum, the right to choose whether to bear children or not. These rights are abridged by the state's restriction of abortions to limited circumstances. To justify such an abridgment, the state must demonstrate a compelling interest; no such compelling interest exists to save the Georgia abortion law.

The state's interest in protecting the woman's health no longer supports the restrictions on abortion set forth in the Georgia statute. Medical science now performs abortions more safely than it brings a woman through pregnancy and childbirth. Any state interest in discouraging non-marital sexual relationships must be served by laws penalizing these relationships, and not by an indirect, overly broad prohibition on abortion. There is no evidence, in any case, that abortion laws deter such sexual relationships. The state's purported interest in expanding the population lacks any viability today; government policy in every other area is now squarely against it. And any purported interest in permitting all embryos to develop and be born is not supported anywhere in the Constitution or any other body of law.

Because of its restrictions, the Georgia statute denies to poor and non-white women equal access to legal abortions. It is an undeniable fact that abortion in Georgia and in virtually every other state in the United States is far more readily available to the white,

paying patient than to the poor and the non-white. Studies by physicians, sociologists, public health experts, and lawyers all reach this same conclusion. The reasons for it are not purely economic, *i.e.*, that because abortion is an expensive commodity to obtain on the medical marketplace, it is therefore to be expected that the rich will have greater access to it. It is also because in the facilities which provide health care to the poor, abortion is simply not made available to the poor and non-white on the same conditions as it is to paying patients. As a result, the poor resort to criminal abortion, with its high toll of infection and death, in vastly disproportionate numbers.

Largely to blame are restrictive abortion laws, such as the Georgia statute, in which the legislature has made lay judgments about what conditions must exist before abortions can be legally performed, and has delegated the authority to make such decisions to physicians and committees of physicians with the threat of felony punishment if they err on the side of granting abortion. Unlike more privileged women, poor and non-white women are unable to shop for physicians and hospitals sympathetic to their applications, cannot afford the necessary consultations to establish that their conditions qualify them for treatment, and must largely depend on public hospitals and physicians with whom they have no personal relationship, and who operate under the government's eye, for the relief they seek. The resulting discrimination is easily demonstrated.

The state has confounded the unequal treatment of the poor and non-white by requiring that abortions may only be performed in hospitals accredited by the Joint Commission on Accreditation of Hospitals, thus severely limiting the number of hospitals to which the poor and non-white may have access, without any legitimate state purpose for doing so. The state has also worsened the discriminatory treatment of the poor and non-white by permitting all hospitals to arbitrarily reject abortion patients, including hospitals which have federal constitutional responsibilities not to discriminate by virtue of their public or publicly-subsidized status.

In the absence of any compelling state interest, the harsh discriminatory effect on the poor and the non-white resulting from the operation of the Georgia abortion law denies to poor and non-white women the equal protection of the laws in violation of the Equal Protection Clause of the Fourteenth Amendment.

ARGUMENT.

I.

THE GEORGIA ABORTION LAW INFRINGES UPON THE RIGHT TO MARITAL AND INDIVIDUAL PRIVACY WITHOUT A COMPELLING STATE INTEREST.

A. The Statute Infringes Upon the Right to Privacy.

The right to privacy has been recognized as a constitutionally protected right. The Georgia abortion statute infringes on the right to marital privacy and the woman's right to individual privacy.

1. Marital Privacy.

In *Griswold v. Connecticut*, 381 U.S. 479, this Court recognized the right to marital privacy when the Court voided a state statute prohibiting dissemination of contraceptive information and devices. The Court defined the right to privacy in terms of the right to personal solitude and autonomy and applied it to a "zone of privacy in marriage," thereby setting forth a right that may not be disturbed by the state without a compelling and valid interest.

The explicit recognition in *Griswold* of a right of marital privacy is but one decision in a line of decisions, dating over fifty years, giving constitutional protection to various rights in the procreative, marital and family context, none of which is explicitly enumerated in the Bill of Rights. These decisions include *Skinner v. Oklahoma*, 316 U.S. 535, 536 ("the right to have offspring" is a constitutionally protected "human right"); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (the right to send one's children to private school is derived from "the liberty of parents and guardians to direct the upbringing and education of children

under their control"); and *Meyer v. Nebraska*, 262 U.S. 390, 399 (the liberty guaranteed by the Fourteenth Amendment denotes "the right of the individual to . . . marry, establish a home and bring up children"). More recently, *Loving v. Virginia*, 388 U.S. 1, 12, specifically held that the Due Process Clause of the Fourteenth Amendment protects "the freedom to marry . . . as one of the vital personal rights essential to the orderly pursuit of happiness by free men".

Recognition of the right of privacy asserted in the case now before the Court thus would not usher in a vast increase in judicial power. What has been said pertaining to *Griswold* applies here:

It required no judicial roving at large to reach the conclusion that the freedom of the marital relationship is a part of the bundle of rights associated with home, family, and marriage—rights supported by precedent, history and common understanding. . . . In exercising its powers in *Griswold* to protect a fundamental personal liberty, the Court, far from advancing to a new milestone on the high road of judicial supremacy, was treading a worn and familiar path. Kauper, "Penumbras, Peripheries, Emanations, Things Fundamental and Things Forgotten: The *Griswold* Case," 64 *Mich. L. Rev.* 235, 258 (1958).

This Court, in *Griswold*, endorsed the contention that certain areas of one's life are so personal that they are nobody else's business; that there is a right to simply withdraw into personal intimacy without hindrance by the State, and a right to protection of this private sphere. Without any 'invasion' of the marital bedchamber, and without any attempt by the state to

obtain incriminating evidence, the Court held the Connecticut statute to be an invasion of the protected "zone of marital privacy." Surely, the State had no interest in invading the sanctity, or privacy, of any other decisions involving family planning.

Griswold's act was to prevent formation of the fetus. This, the court found, was constitutionally protected. If an individual may prevent conception, why can he not nullify that conception when prevention has failed? Clark, "Religion, Morality and Abortion: A Constitutional Appraisal," 2 *Loyola U. (L.A.) L. Rev.* 1, 9 (Apr. 1969).

The Georgia statute, by limiting the authorization of abortions to certain situations, puts limits upon the married couple's fundamental right to decide whether or not to bear a child, at the instant when an ovum is fertilized. Until that moment, the couple has complete freedom of choice as to when, whether, and how often they shall produce children. But once fertilization occurs, their freedom of choice ends and they may not choose *not* to have a child. The state thus invades, and even supersedes, a married couple's constitutional right to control the use of their procreative powers. Under *Griswold* it is surely not the means of control, but the *power* to control which is significant.

The existence and enforcement of this statute allows the state to intrude into the very essence of the marital relationship and indeed to affect the very course and fate of the marriage itself. As did the Connecticut anti-contraceptive statute, the Georgia abortion statute unconstitutionally "operates directly on an intimate relation of husband and wife." 381 U.S. at 483.

2. The Right of Privacy of the Individual Woman.

The right to privacy, to seclusion and autonomy, established as to married couples in *Griswold, supra*, surely belongs to individuals as well.

The right of a woman to control her own body, specifically whether or not to continue a pregnancy, is inherent in the decision in *Terry v. Ohio*, 393 U.S. 1, 8-9, that "no right is more sacred . . . than the right of every individual to the possession and control of his own person. . . ." See also *Olmstead v. United States*, 277 U.S. 438, 478 (Brandeis, J., dissenting).

The right of the woman to decide whether to terminate an unwanted pregnancy follows inexorably from the broad principle that she is entitled to be "let alone" by the state and its agents. For a state to adopt such provisions as the State of Georgia has done in this statute represents an impermissible intrusion into her right to her personal integrity and is a deprivation of her personal liberty. By compelling her, against her will, to continue a pregnancy, the woman may be adversely affecting the essential direction and quality of her own life (and perhaps the lives of others with whom she lives and works, as well). If a woman is viewed as an individual entity, and not as a vessel for propagation, each time she determines whether to bear a child or not, she is without doubt making a truly fundamental choice of her life. Women are no longer a vehicle for a determination by others that supervening social interests require their frequent childbearing for the purpose of adding to the population. Through the medium of the abortion law, however, they are subject to the determination of society in general, which (so far as the lawmaking process is concerned)

is largely male, that no woman may make for herself the decision not to complete a pregnancy to term when she does not desire to. As set out below, the state has no compelling interest in demanding that a woman should carry an unwanted child.

Several courts have acknowledged that the woman's right to her physical integrity requires that she be allowed to make the decision as to the termination of her pregnancy without hindrance by the state. These cases stand for the proposition that abortion statutes are wholly inconsistent with the existence of a right so fundamental in nature, and are, therefore, unconstitutional. In one of these cases was the state's interest in the policy expressed in the challenged abortion statute considered to be of sufficiently compelling nature to justify legislative efforts to circumscribe a woman's right to decide, after consultation with her physician, to terminate her pregnancy.

In *People v. Belous*, 71 Cal. 2d 954 (1969), cert. denied, 397 U.S. 915, for example, the Supreme Court of California, in striking down as unconstitutional the pre-1967 abortion law of California, stated:

The rights involved in the instant case are the woman's right to life and to choose whether to bear children. The woman's right to life is involved because childbirth involves risks of death.

The fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this Court's repeated acknowledgment of a "right of privacy" or "liberty" in matters related to marriage, family, and sex. 71 Cal. 2d at 963 (footnotes and citations omitted).

See also *Babbitt v. McCann*, 310 F. Supp. 293 (E.D. Wis. 1970), *appeal dismissed per curiam*, 400 U.S. 1, where the court said:

The police power of the state does not . . . entitle it to deny to a woman the basic right reserved to her under the Ninth Amendment to decide whether she should carry or reject an embryo which has not quickened. 310 F. Supp. at 302.

The right "to be let alone" has, to be sure, been qualified in a few cases involving physical intrusion into the body, but only where the state interest has been compelling, that is, where the exercise of that right has threatened the rights of other members of society. For example, the power of the state to require vaccinations and to quarantine persons suffering from contagious diseases, although upheld, has been limited to situations involving "great dangers", and "the safety of the general public." *Jacobson v. Massachusetts*, 197 U.S. 11, 29 (1904). In *Jacobson*, even so minor an infringement of liberty and of the individual's sovereignty over his body as vaccination was held to require a strong justification.

Also supporting the individual's right to control his own body are recent cases which have upheld the individual's right to refuse medical treatment, even though such a refusal will clearly result in death. See e.g., *Erickson v. Dillgard*, 44 Misc. 2d 27, 252 N.Y.S. 2d 705 (Nassau County Sup. Ct. 1962); *In re Brooks Estate*, 32 Ill. 2d 361, 205 N.E. 2d 435 (1965).

In a case where blood transfusions were permitted without the patient's consent, *Pres. & Directors of Georgetown College, Inc. v. Jones*, 231 F. 2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978, the

court based its order on two grounds: (1) the state had an interest in preserving the life of a woman whose small child might become a public charge if she died; and (2) the patient was too weak from loss of blood to be capable of making a competent decision. This case was followed in *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965), in which blood transfusions were ordered while the patient was semiconscious, but withdrawn several days later when the patient regained consciousness.

These cases demonstrate that an individual has a right to refuse medical treatment unless the state's interest is so great that the rest of society will be endangered absent such treatment. Similarly, the state has no right to *prevent* an individual woman from obtaining medical treatment she *desires*, where that treatment represents no danger to the community as a whole.

B. The Statute Infringes Upon Fundamental Constitutional Rights Without Serving Any Compelling State Interest.

Where there is a significant encroachment upon personal liberty, the State may prevail only upon showing a subordinating interest which is compelling. *Bates v. Little Rock*, 361 U.S. 516, 524.

The Georgia abortion statute does not serve any compelling state interest to justify its infringement upon constitutionally protected rights. The statute does not serve any valid health purpose; instead it causes a severe health problem. The state has no valid interest in regulating morality indirectly through an abortion statute. The state has no valid interest in increasing population through an abortion statute. And the state has

no interest in requiring that all embryos develop and be born.

1. The Statute Serves No Health Interest of the State; On the Contrary, It Has Created a Severe Health Problem.

Because a state has a valid interest in protecting the health of its citizens, one frequently-asserted justification for restrictive abortion laws has been the state's concern with preserving the health of the woman because of the medical dangers associated with abortion in the past. Indeed, the history of abortion legislation in the United States shows that such a concern was a primary, if not the sole, reason for the passage of such restrictive laws during the nineteenth century. But current medical knowledge and techniques have drastically reduced the hazards of abortion, and any such state interest has disappeared. Now, pregnancy itself may be more harmful to woman's health than an abortion performed under medically approved conditions.

a. *The History of the Abortion Statute.*

Abortion before "quickeining" (*i.e.*, when the first fetal movements are felt by the pregnant woman, usually about the fourth or fifth month) was not a crime under the common law of England; even after quickening, abortion was only a misdemeanor. 3 Coke, *Institutes* 50 (1648). American law followed suit until the nineteenth century, when legislation making abortion prior to quickening a crime began to appear. These new laws were designed to protect the health of the woman, as *State v. Murphy*, 27 N.J.L. 112, 114 (Sup. Ct. 1858) declared:

The design of the [abortion] statute was not to prevent the procuring of abortions, so much as to guard the health and life of the mother against the consequences of such attempts.

The risk of even hospital abortions in the 19th century was formidable, but it is now safer for a woman to have a hospital therapeutic abortion during the first trimester than to bear a child. *People v. Belous, supra* at 965.

"At the time the abortion laws were passed, the laws made some medico-legal sense. But now, in view of the progress of medical science, these laws . . . make no sense whatsoever." Hall, "Abortion Laws: A Call for Reform," 18 *DePaul L. Rev.* 584, 585 (1969). The rate of maternal mortality from complications of or associated with pregnancy and childbirth (excluding induced abortion) is 18 deaths per 100,000 live births, while the rate of mortality associated with legal abortions performed in hospitals at an early stage of gestation is three deaths per 100,000 abortions. Tietze, "Mortality with Contraception and Induced Abortions," 45 *Studies in Family Planning* 6 (Sept. 1969).

There is no longer any health interest served by Georgia's abortion statute.

b. *The Adverse Effect Upon Health of the Georgia Law.*

Present restrictive abortion laws, instead of protecting the health of women, have produced a result in direct conflict with that goal. When unable to obtain competent medical treatment, meeting proper medical standards, in appropriate medical facilities, women commonly resort to abortions performed under "back-alley" conditions which often lead to illness and death. The law has thus created "a public health problem of pandemic proportions." Hall, "Abortion in American

Hospitals," 57 *Am. J. Pub. Health* 1933, 1934 (1967). The number of criminal abortions performed annually in the United States is not known but has been estimated at from 200,000 upwards. The incidence of infection and permanent physical damage is high, and death is a constant threat. Recent studies reveal a high—and increasing—incidence of infected abortions in the hospitals studied (primarily large city hospitals) and describe such septic abortions as a chief cause of maternal deaths. *See, e.g.*, Moritz & Thompson, "Septic Abortion," 95 *Am. J. Obst. & Gynec.* 46 (1966).

It is thus clear that illegal abortions present a significant health problem. By making abortion a crime (unless it comes within the categories of the existing law), the state has succeeded in making highly dangerous a form of conduct which serves a necessary function for society and which can be performed safely under the proper medical conditions. *See Kummer, "A Psychiatrist Views Our Abortion Enigma," in The Case for Legalized Abortion Now 114 (Guttmacher ed. 1967).* The Georgia statute is thus contrary to, rather than in furtherance of, any state interest in protecting the health of its women.

2. The State Has No Valid Interest in Indirectly Legislating Morality, and the Statute Does Not Actually Serve Any Moral Purpose.

It is sometimes asserted that the State has a moral interest in prohibiting abortion because the availability of abortions will tend to encourage promiscuity. If the Georgia legislature is concerned with deterring fornication and adultery, it may enforce statutory prohibitions of and penalties for those acts themselves. "It may not do so, however, by making the penalty a personally, and socially, undesired pregnancy." *Baird v. Eisenstadt*,

429 F. 2d 1398, 1402 (1st Cir. 1970), *prob. juris. noted*, 401 U.S. 934.

Even if some state interest in circumscribing promiscuity could be shown, there is no evidence that promiscuity has been decreased or even affected by the existence of abortion laws. If the prevention of such conduct were indeed one purpose of the legislation, the statutory scheme is too indirect to accomplish the legislative intent. Since married women who conceive unwanted pregnancies by their husbands are equally subject to the act, the method of control is not limited to the "evil" sought to be regulated. The statute involved here does not purport to distinguish between married and unmarried women. Even where premarital or extramarital relationships are banned, as in Connecticut at the time of the *Griswold* opinion, a ban on abortions by married couples in no way reinforces the state's ban on other sexual relationships. "At most [such a] broad ban is of marginal utility to the declared objective." *Griswold v. Connecticut*, *supra* at 506 (White, J., concurring).

3. The State Has No Interest in Increasing Its Population; On the Contrary, Its Interest, If Any, Is in Limiting Population Growth.

In view of the increasing public concern over our rapidly multiplying population, any supposed state interest in increasing the number of lives in being can hardly be raised as a justification for the prohibition of abortion. Indeed, the growing emphasis of both federal and state agencies upon preplanning of families and limitation of their size makes manifestly inconsistent treating the termination of pregnancy as a crime, while

birth control devices are not merely permitted but are openly promoted and encouraged by the government. See, e.g., 42 U.S.C. 705(a)(12); 45 C.F.R. 220.20, 220.21.

4. **The State Has No Interest in Requiring That All Embryos Develop and Be Born.**

There is not now, nor has there ever been, a state interest which requires that all embryos develop and be born.

a. *The Law Has Never Restricted Abortions for the Purpose of Protecting the Embryo.*

The English common law, followed in this country until the advent of statutory law, permitted abortion before quickening with the woman's consent. The woman's right to abort her pre-quickened fetus was thus "an ancient common-law liberty" of which she was not deprived until the nineteenth century. Means, "The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality," 14 *N.Y.L.F.* 411, 420, 453 (1968). Even under the current Georgia statute, the woman is not prosecuted or punished for her complicity in obtaining an illegal abortion or for aborting herself.

If anything, the historical development of the abortion statutes reflects an interest in protecting the well-being of the woman. "The new statutes were inspired by reverence for life, to be sure; but the life they revered was the pregnant woman's, not that of the unquicken foetus." *Id.* at 508.

b. *There Is No Legal Recognition of the Fetus as a Person; Live Birth Is Required Before Any Rights Attach.*

All of the statutes and rules which are generally relied upon to show that an embryo or fetus is legally equivalent to a born child "require a live birth or reflect the interest of the parents." *People v. Belous, supra* at 968, 968 n. 12.

(1) No recovery is permitted for injuries negligently inflicted upon a fetus by a third person unless the fetus is *born alive*. Prosser, *Law of Torts* 336 (4th ed. 1971).

(2) No recovery whatsoever is permitted in many states for wrongful death where there is a stillbirth. Even in those jurisdictions which recognize such a cause of action, it is a recognition on behalf of the parents, who have suffered a distressing wrong in the loss of a child whose birth they desired. *Id.* at 337. Moreover, every one of those cases requires that the injury have occurred when the fetus was *viable* (the cases say "quick"). See 15 A.L.R. 3d 992 (1967).

(3) The fetus has no property rights; it must be *born alive* to take property. See, e.g., *People v. Belous, supra*, at 968 n. 12.

c. *The View That "Human Life" Commences With Conception Is a Philosophical Conclusion Not Supported by Scientific Evidence.*

The view that human life commences with conception cannot be supported by any scientific evidence one way or the other. At what point a fetus becomes a "human being" is a subject more fitting for philosophical debate than for scientific judgment. Precisely because human development is a continuum, any choice

of a starting point for an individual human being is largely arbitrary. Choosing the point of fertilization of the egg by the sperm is no more logical or meaningful than choosing any other.

It is said that, as a biological fact, life begins with the fertilized ovum. But in one sense 'life' began in the prehistoric slime and has been continuous since. The question is not when life begins but when human personality begins. This is where the phrase 'the unborn child' subtly begs the question.

The phrase 'unborn child' can be used, without offense to common sense, in respect of the viable foetus, that is, after about the seventh month of pregnancy, when the foetus is capable of surviving apart from the mother. But the further one goes back in the development of the foetus the more questionable its application becomes. Williams, *The Sanctity of Life and the Criminal Law*, 197 (1957).

The existence of a conceptus cannot be equated with the life of a grown woman. This woman is—beyond dispute—a human being. To equate her life and her constitutional rights with those of a non-viable fetus is to make a moral judgment. Any individual is entitled to adopt such a moral judgment for guidance in his or her private life, but it is surely a judgment which he cannot enforce upon others through legislation. See *Epperson v. Arkansas*, 393 U.S. 97.

5. Conclusion.

A single conclusion is dictated by all of the above: the Georgia abortion statute serves no compelling state interest. Because it fails to serve any compelling state interest, its invasion of fundamental rights is in clear violation of the Federal Constitution.

II.

THE APPLICATION AND EFFECT OF RESTRICTIVE ABORTION LAWS, SUCH AS THE GEORGIA ABORTION LAW, RESULTS IN DISCRIMINATION AGAINST POOR AND NON-WHITE WOMEN IN EXERCISING THEIR FUNDAMENTAL INTEREST IN MARITAL AND INDIVIDUAL PRIVACY, DENYING TO THEM THE EQUAL PROTECTION OF THE LAWS.

While *amici* contend that to receive proper medical care in the form of an abortion approved and performed by a physician is, by itself, a fundamental interest protected by the Constitution (Part I, *supra*), it is not necessary for abortion to be declared a constitutional right to hold that its discriminatory denial violates guarantees of equal protection. Even when an interest is not found to be fundamental under the Due Process Clause, it may be deemed fundamental under the Equal Protection Clause, and unequal treatment with respect to that interest upheld only on a very strong showing of justification. Note, "Developments in the Law—Equal Protection," 82 *Harv. L. Rev.*, 1065, 1130 (1969).

A. Factual Data Demonstrate Discrimination Against the Poor and Non-White.

The State of Georgia has established a set of categories describing the circumstances under which women may obtain abortions within the State. On their face, these categories allow this treatment for all women who are similarly situated with respect to those circumstances, and excludes from this treatment all others.

Presumably, therefore, those women who qualify for a legal abortion according to the terms of the statute should be able to obtain one, regardless of their race

or socio-economic status. There is nothing demonstrable in the differences of skin color or economic condition which suggests that a substantially smaller proportion of the poor or the non-white fall into these categories than do the white and the non-poor, or that the poor and non-white have a substantially different moral attitude on abortion.

On the contrary, a recent study of births occurring between 1960 and 1965 led investigators to conclude that one-third of Negro (as contrasted with one-fifth of white) births were unwanted. "This high level of unwanted births among Negroes indicates the magnitude of the burden of unwanted dependents that is borne by this population. . . ." Bumpass and Westoff, "The Perfect 'Contraceptive' Population," 169 *Science*, 1177, 1179 (1970). Unwanted births were in general more than twice as high for families with incomes of less than \$3000 as for those with incomes of over \$10,000; this differential was "particularly marked among Negroes." *Id.* The results indicated, in the view of the investigators, that there is a "coincidence of poverty and unwanted births rather than a propensity of the 'poor' to have unwanted children." *Id.*

One explanation for this high level of unwanted births among the poor and the non-white is surely the fact that they do not have equal access to abortions. Data demonstrate that the poor and the non-white do not receive this medical treatment on the same terms as do others. They thus suffer a particularly harsh and adverse effect from the operation of this statute, as they do from that of the other restrictive abortion laws which have existed and currently exist in the United

States. Dr. Alan F. Guttmacher has summed up the evidence:

Both in regard to incidence and indications between patients on private and clinic services and voluntary and municipal hospitals . . . it has long been apparent . . . that municipal hospitals follow the letter of the law of the abortion statute much more exactly than voluntary hospitals, and also that private patients are generally treated by a more lenient interpretation of the law than service patients. Guttmacher, "Abortion—Yesterday, Today and Tomorrow," in Guttmacher (ed.), *The Case for Legalized Abortion Now* (1967).

The additional burdens placed upon indigent women by public hospitals before these women can obtain abortions (obtainable with far greater ease elsewhere by those who can pay) have been discussed by the two federal courts which examined the procedures at the District of Columbia General Hospital, *Doe v. Gen. Hosp.*, 313 F. Supp. 1170 (D.D.C. 1970), 434 F. 2d 423 and 434 F. 2d 427 (D.C. Cir. 1970). Because the poor rely primarily upon public hospitals for their medical services, denials or delays at those institutions are tantamount to a denial of prompt medical care solely because these women are without funds. "[T]he mere state of being without funds is a neutral fact—constitutionally an irrelevance, like race, creed, or color." *Edwards v. California*, 314 U.S. 160, 184 (Jackson, J., concurring). Yet that state has led to very different medical treatment where restrictive abortion laws exist.

Dr. Robert E. Hall has collected and reported data supporting this conclusion. In New York City, between 1960 and 1962, Dr. Hall found that:

... the ratio of therapeutic abortions to live births in the proprietary hospitals was 1:250; on the private services of the voluntary hospitals, 1:400; on the ward services of the same voluntary hospitals, 1:1,400; and in the municipal hospitals, 1:10,000. The same inequity pertains to ethnic origin. The rate of therapeutic abortions per live births among white women in New York is 1 per 380, among nonwhites 1 per 2,000, and among Puerto Ricans 1 per 10,000. Hall, "Abortion in American Hospitals," 57 *Am. J. Pub. Health* 1933, 1934 (1967).

In a survey of 65 randomly selected major American hospitals, Dr. Hall similarly discovered that the rate of therapeutic abortions was *3.6 times higher on the private services* of these hospitals than on their ward services. Hall, "Therapeutic Abortion, Sterilization and Contraception," 91 *Am. J. Obst. & Gynec.* 518, 519 (1965).

Kenneth R. Niswander has substantiated similar data from a study of Buffalo, New York, hospitals. Niswander, "Medical Abortion Practices in the United States," in Smith (ed.), *Abortion and the Law* 53 (1967).

Furthermore, he has written:

Hospitals vary greatly in their abortion practices. At the Los Angeles County Hospital, which treats only clinic patients . . . from 1946 to 1951 there was an incidence of one therapeutic abortion per two thousand eight hundred sixty-four (2,864) deliveries. At the opposite extreme, one finds reputable hospitals permitting abortion for one out of every 35-40 deliveries. The variation in the hospitals surveyed by [Robert E.] Hall extended from

no abortions in 24,417 deliveries to one in 36 deliveries. It seems inconceivable that medical opinion could vary so widely. *Socioeconomic factors must be playing a major role in the decision to abort in certain institutions.* *Id.* at 54-55 (emphasis added).

Data collected from New York City by other investigators for the period 1951-1962 revealed that:

Therapeutic abortion occur[red] most frequently among the white population by a considerable margin. The white ratio [was] more than *five times* that among the nonwhites and *26 times* that among the Puerto Ricans. (Well over 90 per cent of all therapeutic abortions in New York City [were] performed on white women.) *Gold, et al., "Therapeutic Abortions in New York City: A 20-Year Review," 55 Am. J. Pub. Health 964, 966 (1965)* (emphasis added).

A nationwide survey of all short-term general hospitals participating in the Professional Activities Survey from 1963 to 1965 led to this conclusion:

. . . [T]he incidence of therapeutic abortion was almost twice as high among white women as among the nonwhite group. . . . *Tietze, "Therapeutic Abortions in the United States," 101 Am. J. Obst. & Gynec. 784, 786 (1968).*

Similar statistics and conclusions appear throughout the literature in this area:

Perhaps the greatest injustice resulting from our present policies is the creation of a double standard for private and indigent patients. . . . Almost universally greater consideration is extended to the

private patient for a multitude of reasons which, not infrequently, include a recognition of their social and economic prestige. Mandy, "Reflections of a Gynecologist," in Rosen (ed.), *Abortion in America* 288-89 (1967).

* * *

The rich and the poor, it should be noted, are not treated alike: many ethical physicians, for instance, are much more lenient in their application of indications for therapeutic abortion to private patients than to indigent patients on municipal hospital services. It is the 'private practice' patient, therefore, who can more readily obtain a therapeutic abortion. Kleegman, "Planned Parenthood: Its Influence on Public Health and Family Welfare," in Rosen (ed.), *Abortion in America* 254, 256 (1967).

A partial explanation for the marked disparity in these figures appears to lie in the far lower incidence of abortions performed for psychiatric reasons among poor and non-white women. In an era when *non-psychiatric* medical reasons for abortions have steadily decreased (Guttmacher, "The Shrinking Non-Psychiatric Indications for Therapeutic Abortion" in Rosen (ed.), *Therapeutic Abortion* 12 (1954)), a steadily increasing number of abortions have been performed for psychiatric reasons. Poor and non-white women have not been the recipients of this treatment, however, to the same extent as their white and wealthier sisters. As Hall wrote in 1965, the discrepancy documented above

... may be attributed to the higher incidence of abortions for psychiatric indications among pri-

vate patients. Whereas at Sloane Hospital [for Women, in New York City] one therapeutic abortion was performed for psychiatric reasons per 1,149 deliveries on the ward service, the comparable ratio for the private service was one per 104. . . . It would appear therefore that private patients with unwanted pregnancies are more often referred for primary psychiatric evaluation and/or that psychiatric justification for abortion is more easily obtained for private patients. Hall, "Therapeutic Abortion, Sterilization and Contraception," 91 *Am. J. Obst. & Gynec.* 518, 519, 522 (1965).

Dr. Hall's survey of 65 major hospitals confirms the same wide discrepancy in granting psychiatrically-related abortions. (Hall, *op. cit.* at 518.)

Why has this phenomenon occurred? Perhaps because

" . . . by the very nature of things, ward patients are less likely to have the necessary consultations requested, including the psychiatric, and to have the necessary recommendations made and accepted by a hospital board, than are their well-to-do sisters. Ethical and conscientious physicians decry this fact, but nevertheless find it impossible to controvert. . . . Rosen, "A Case Study in Social Hypocrisy," in Rosen (ed.), *Abortion in America* 299, 306-07 (1967).

"Reform" legislation such as that in issue here is far from a complete answer to this problem. As one writer has noted:

. . . [I]t must be recognized that moderate reform is essentially middle-class reform. It benefits

those who are sufficiently well-educated, well-connected and well-financed to take advantage of the liberalized law. Where will the ghetto dweller find a psychiatrist to testify that she runs a grave risk of emotional impairment if she is forced to give birth to her *nth* baby? Packer, *The Limits of the Criminal Sanction* 344 (1968).

The Georgia statute's onerous requirements of consultation and review, moreover, limit access to legal abortion to those who can afford all the unnecessary services mandated by the statute. See §§26-1202(b)-(3), (4), (5) and (6), 26-1202(c), Ga. Code Ann. These provisions require a woman to retain a physician to approve her request, retain two other physicians to review and concur in that approval, have access to a licensed and accredited hospital and a committee therein to further approve the application, and possibly be prepared to defend her request in a court action brought by relatives of the fetus to the second degree (which may include persons who are total strangers to her). Only the latter provision was struck down by the court below. See Appellant's Jurisdictional Statement herein, App. F., pp. 2f, 3f, 4f.

B. As a Result of the Disproportionate Unavailability of Hospital Abortions to Them, the Poor and the Non-White Resort to Unsafe Criminal Abortions Which Lead to High Mortality and Morbidity Rates.

While socioeconomic conditions never *per se* legally warrant therapeutic abortion, socioeconomic status nevertheless frequently determines whether or not an abortion will be performed, and if performed, whether that self-same abortion will be

therapeutic or criminal. Rosen, "Psychiatric Implications of Abortion: A Case Study in Social Hypocrisy," 17 *W. Res. L. Rev.* 435, 450 (1965).

Criminal abortion has been described as the greatest single cause of maternal mortality in the United States; it is one of the greatest causes of disease, infection, and resulting sterilization as well. *See* Leavy & Kummer, "Criminal Abortion: Human Hardship and Unyielding Laws", 35 *So. Cal. L. Rev.*, 123 (1962); *see also* *People v. Belous, supra* at 965-966. The poor and the non-white suffer disproportionately from the "back-alley" abortionists, whose services they seek out in lieu of the medically safe hospital abortions generally denied them.

California, the only state known to officially compile such figures, in its most recent published report notes that approximately 7 percent of that state's non-white female population subjected themselves to criminal abortion in 1968, as opposed to only 1½ percent of the state's white female population. (California Dept of Public Health, *Third Annual Report on the Implementation of the California Therapeutic Abortion Act*, Tab. 4 (1970).

The often tragic results of these abortions are also documented. In their New York study, Drs. Gold, *et al.*, *op. cit.* at 970-71, noted that the ratio of criminal abortion deaths per 1,000 live births was 4.0 for white women and 16.2 for non-whites. Likewise, Dr. Hall's 1960-62 study led him to conclude that approximately half of the puerperal deaths among New York's Negroes were due to criminal abortions as opposed to only a quarter of the puerperal deaths among white women. Hall, *op. cit.*, 57 *Am. J. Pub. Health* at 1934.

In Georgia itself, non-hospital abortions caused the deaths of 205 residents between 1950 and 1969. Of these 205 non-hospital abortion deaths, 143 (70%) were of black women. Of the 25 Georgia women who died as a consequence of legal abortions between 1965 and 1969, 22 (88%) were black. While the abortion mortality rate for white Georgia women fell 80% from 1950-54 to 1965-69 (partially reflecting adopting of the instant, "reform" law in 1968), abortion mortality among black Georgia women declined by only 33% between the same two five-year periods. "Non-hospital abortion mortality in Georgia is primarily a black health problem." U.S. Dep't of HEW, Public Health Service, Center for Disease Control, *Abortion Surveillance Report* 10 (1970), citing Rochat, *et al.*, Division of Maternal Health, Georgia Dep't of Public Health, "An Epidemiological Analysis of Abortion in Georgia" (1970).

C. Where Abortion Restrictions Have Been Eliminated, the Poor and the Non-White in Fact Receive Abortion Services in a Non-Discriminatory Manner.

In sharp contrast to the above data has been the experience in New York State since July 1, 1970, when categorical restrictions on abortion were eliminated. See N.Y. Pen. Law §125.05 (McKinney Supp. 1970). On April 5, 1971, New York City health officials reported that the city's public hospitals, which restricted abortions to city residents, were performing an average of 511 a week, and the "vast majority" of those women would be unable to afford abortions in private hospitals. *N.Y. Times*, Apr. 6, 1971, at 25.

A later report, issued on June 29, 1971, was even more revealing:

In the first six weeks, non-whites and Puerto Ricans, who had little access to legal abortions prior to the law, received half the abortions done on women in [New York City]. In the first nine months, 31% of the city's abortions done on state residents were reimbursable under Medicaid. *American Medical News*, July 12, 1971, at 9.

It is clear from this evidence that where the law has eliminated restrictions on the obtaining of abortions, the poor and non-white women who were previously unable to exercise the financial and other kinds of leverage required to have a "therapeutic" abortion, are able to obtain medically safe abortions on an equal basis with all other women, and they do obtain them to at least the same extent as their more privileged sisters. One result has been a drop in the maternal mortality rate: New York City hospitals now report treating far fewer victims of "botched" illegal abortions than they did in years past. "The maternal mortality rate—to which criminal abortions have always contributed a major portion—is now at a record low of 2.3 per each 10,000 live births, compared with 5.2 . . . at this time last year." *Id.*

D. The Impact of the Restrictive Abortion Law Effectively Denies Equal Protection to the Poor and Non-White.

It has been amply demonstrated above that poor and non-white women are not treated equally with other women in obtaining lawful abortions. However

neutral its facial appearance, and however unexceptionable its underlying intent, the practical effect of a statute in denying equal treatment to classes of persons, such as the poor or the non-white, must be measured by the Court.

Though the law itself be fair on its face and impartial in appearance, yet, if it is applied and administered by public authority with an evil eye and an unequal hand, so as practically to make unjust and illegal discriminations between persons in similar circumstances, material to their rights, the denial of equal justice is still within the prohibition of the constitution. *Yick Wo v. Hopkins*, 118 U.S. 356, 373-74.

The standard articulated in *Yick Wo* has been consistently applied by this Court. Moreover, it has been applied to statutes which have a natural discriminatory effect, whether or not there is evidence of any "evil" public administration.

Where the class affected is the poor, see *Griffin v. Illinois*, 351 U.S. 12 (state's provision of criminal appeal, but not of free transcript held to be an effective denial of equal protection to poor defendants); *Harper v. Virginia Bd. of Elections*, 383 U.S. 663 (state's exaction of a poll tax from all voters held to be an effective denial of equal protection to poor voters); *Shapiro v. Thompson*, 394 U.S. 618 (state's refusal to make welfare payments to residents of less than one year held to be an effective denial of equal protection to poor recent residents and to the foreign poor who wish to travel to the state); *Douglas v. California*, 372

U.S. 353 (state's provision of criminal appeal, but where appellate court decides in advance of hearing whether appointment of counsel for indigent would be "helpful", held to be an effective denial of equal protection to poor defendants). *See also Williams v. Oklahoma City*, 395 U.S. 458; *Gardner v. California*, 393 U.S. 367; *Long v. District Court of Iowa*, 385 U.S. 192; *Rinaldi v. Yeager*, 384 U.S. 305; *Hobson v. Hansen*, 269 F. Supp. 401 (D.D.C. 1967), *aff'd sub nom. Smuck v. Hobson*, 408 F. 2d 175 (D.C. Cir. 1969).

Where the class affected is non-white, see *Gomillion v. Lightfoot*, 364 U.S. 339 (state's drawing of voting district lines which effectively excluded Negroes from a city district held to be an effective denial of equal protection to Negroes); *Patton v. Mississippi*, 332 U.S. 463, and *Smith v. Texas*, 311 U.S. 128 (state's facially neutral system of jury selection was administered to largely exclude Negroes held to be an effective denial of equal protection to Negroes).

The impact of the cases cited immediately above is that, while the state may not be bound to confer the benefit at issue (here, the categorical exceptions to its basic anti-abortion statute), if it chooses to do so it is obliged not to effectively preclude enjoyment of the benefit to classes like the poor and non-white. Thus, in *Griffin v. Illinois*, *supra*, the state was not obliged by due process to provide appeals from criminal convictions, but since it had chosen to do so, it could not provide them in a manner that effectively denied poor persons access to the appeal process.

The effect of the [Griffin] decision is to require Illinois to take account of economic inequities not of its own creation. Note, "Developments in the Law—Equal Protection," *supra*, 82 *Harv. L. Rev.* at 1178.

If the State of Georgia had chosen not to regulate the medical practice of abortion, the prevailing standards of medical practice in the United States today would sanction its performance without categorical restrictions. See *AMA, Policy Regarding Abortion* (Resolution of *AMA* House of Delegates, June 25, 1970) discussed in "AMA Eases Abortion Rules," *N.Y. Times*, June 26, 1970, at 1; *American College of Obstetrics & Gynecology, Policy on Abortion*, discussed in *Medical Tribune*, Oct. 12, 1970, at 1. It is true that the poor and non-white would still be limited in obtaining treatment by the natural factors of inability to pay, not having a family physician, and the limited number of free or subsidized-care facilities in their communities. Nevertheless, it is clear that the state's entry into the field has aggravated the natural limitations of the poor and the non-white by imposing artificial limitations, as well as onerous and costly procedural requirements. The state has elected, first, to penalize the provision of abortion services by everyone, including physicians. It has then permitted physicians to provide this treatment for certain statutory categories of qualified women. At the same time, the state has prescribed necessary steps to secure qualification which are so burdensome as to make it extremely difficult for the

poor and non-white to qualify. This results in an effective denial of equal protection to the poor and non-white.

We have contended (Part I, *supra*) that abortion to a woman is a fundamental interest, and it is being restricted by the state without a compelling state interest. The discrimination in the application and effect of the statute likewise lacks a compelling state interest, or even any rational connection to a legitimate state purpose.

In sanctioning the vastly disproportionate exclusion of the poor and non-white from abortion services, the state cannot assert that its purpose is to cut down the number of abortions. Where abortion is otherwise lawful, and the poor or non-white woman legally qualifies, the state has no interest in eliminating that which it does not prohibit. The impact on the poor and non-white cannot be justified in terms of state budget-saving, since restrictive abortion laws do not bear any rational relation to the allocation of state resources, and they are clearly not a mere economic regulation. *See Dandridge v. Williams*, 397 U.S. 471. Even were budget-saving asserted, in that medical care for the poor and non-white is often subsidized by public funds (e.g., the Medicaid program, 42 U.S.C. 1396 *et seq.*), it cannot be accomplished by arbitrarily selecting classes to suffer the deprivation. *Shapiro v. Thompson*, 394 U.S. 618.

III.

WHERE THE STATE HAS PERMITTED ABORTIONS TO TAKE PLACE IN CERTAIN HOSPITALS UNDER CERTAIN CONDITIONS, BUT HAS DELEGATED UNREVIEWABLE AUTHORITY WITHOUT STANDARDS TO A PRIVATE BODY TO DECIDE IN WHICH HOSPITALS ABORTIONS MAY TAKE PLACE, AND HAS DELEGATED UNREVIEWABLE AUTHORITY TO PHYSICIANS AND COMMITTEES OF PHYSICIANS TO DECIDE UNDER WHICH CONDITIONS ABORTIONS MAY TAKE PLACE, AND SAID PHYSICIANS HAVE COMPELLING REASONS TO SKEW THEIR DECISIONS AGAINST GRANTING ABORTIONS, AND WHERE SUCH DELEGATIONS OF AUTHORITY ARE LIKELY TO RESULT AND IN FACT RESULT IN DISCRIMINATION IN OBTAINING ABORTION AGAINST THE POOR AND NON-WHITE, THE STATE HAS DENIED TO THE POOR AND NON-WHITE THE EQUAL PROTECTION OF THE LAWS.

Two other aspects of the Georgia abortion law result in an effective denial of equal protection to the poor and the non-white. One is the requirement that abortions, to be lawful, must be performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals. The second is the provision that other physicians must approve the procedure.

A. Restricting Lawful Abortions to Accredited Hospitals Results in Discrimination Against the Poor and Non-White.

§26-1202(b)(4), Ga. Code Ann., provides that abortions can only be performed in state-licensed hospitals which are also accredited by the Joint Commission on Accreditation of Hospitals (JCAH). Eighty-three of 214 state-licensed hospitals in Georgia are so

accredited, leaving 103 Georgia counties without an accredited hospital. *See Appellant's Jurisdictional Statement herein, p. 18, App. G.*

The JCAH is a private, voluntary national accrediting body located in Chicago, Illinois. It surveys and accredits only those hospitals which request this service. *See Silver & Worthington, "Regulation of Quality of Care in Hospitals," 35 Law & Contemp. Problems, 305, 310-11 (1970).*

The state has delegated to this private body the authority to choose which Georgia hospitals may lawfully perform abortions. It is instructive to compare this delegation of authority with the three broad areas of delegation which have traditionally been upheld as constitutionally valid. *See McGautha v. California, 91 S. Ct. 1454, 1499-1504 (1971) (Brennan, J., dissenting).*

First, the Georgia legislature has not delegated this power to select which of its hospitals may perform abortions under reasonably fixed statutory standards. *McGautha v. California, supra, 91 S. Ct. at 1502, citing Communist Party of U.S. v. SACB, 367 U.S. 1; U.S. v. Rock-Royal Co-Op., 307 U.S. 533.* The legislature has provided no standards at all, and indeed the JCAH would not be bound to accredit by state-fixed standards. Nor has the state impliedly incorporated by reference the fixed and existing standards of an expert body. *See, e.g., Schecter Poultry Corp. v. U.S., 295 U.S. 495; Carter v. Carter Coal Co., 298 U.S. 238.* The JCAH standards are subject to change, and have in fact been changed since the adoption of §26-1202 (b)(4), Ga. Code Ann. *See JCAH, Accreditation Manual for Hospitals 1970 (1971), setting forth new*

accreditation standards which went into effect July 1, 1971.

Second, the Georgia legislature has not delegated a rule-making power to technical experts, under generally declared policy goals, by which the rule-making process itself serves to illuminate the policy decisions being made and allows for meaningful legislative supervision or review. *McGautha v. California, supra*, 91 S. Ct. at 1502-03, citing, e.g., *U.S. v. Grimaud*, 220 U.S. 504 (Dept. of Agriculture's rule-making power to "improve and protect" the national forests); *Red Lion Broadcasting Co. v. FCC*, 399 U.S. 367 (the "fairness" doctrine). Again, of course, the JCAH would not be bound by state-fixed policy goals even if they were declared in the statute, which they are not. If § 26-1202(b)(4), Ga. Code Ann., may be read to support an inference that the state is concerned about the quality or integrity of the facility performing abortions, this concern would seem to be satisfied by the requirement of state licensing. The legislature obviously has the power of supervision and review of its state licensing standards, ~~which is a critical reservation of legislative power in a valid delegation of authority.~~ 91 S. Ct. at 1503. The state has no such power of review over the rule-making functions of JCAH, and indeed the rule-making functions of JCAH are in no wise guided by any express or inferable purpose in the Georgia law.

Even assuming an inferable and legitimate state purpose in the quality and integrity of facilities performing abortions which, *arguendo*, might not be satisfied by state licensing requirements, the delegation of this authority to JCAH would seem facially to be an irrational classification. The JCAH *Accreditation Manual for Hospitals, supra*, contains no special provisions for

abortion services, nor does it even mention the word. To the extent that the quality and integrity of the facility are concerned, the JCAH accreditation requirement would also seem to be an irrational classification for the performance of abortions because there is no articulated nor understandable reason why abortion requires a different quality or integrity of hospital organization than more difficult and dangerous forms of medical treatment, such as neurosurgery, open heart surgery or organ transplants. For all such medical services, the people of Georgia may choose to enter a state-licensed or a licensed and accredited hospital. For abortion alone, the women of Georgia are not allowed to enter a state-licensed hospital unless it is also accredited.

Third, the rule-making or adjudicative functions here delegated by the Georgia legislature to JCAH (i.e., to adopt standards for and to decide which hospitals qualify to perform abortions) are not premised "upon an explanation of both the findings and reasons for a given decision", establishing a body of precedent from which general principles may be deduced. 91 S. Ct. 1503-04, again citing *Red Lion Broadcasting Co. v. FCC, supra*. In fact, the "findings and reasons" for JCAH accreditation decisions are treated by JCAH as confidential, and are not even shown to the Secretary of Health, Education and Welfare for Medicare certification purposes, much less to the Georgia legislature. See *Silver & Worthington, op. cit., supra* at 325.

For the foregoing reasons, *amici* contend that the Georgia legislature, in §26-1202(b)(4), Ga. Code

Ann., has delegated its authority to select which hospitals may perform legal abortions in Georgia in a manner violative of the Due Process Clause of the Fourteenth Amendment. *McGautha v. California, supra*, 91 S. Ct. at 1500, n. 22; *Yick Wo v. Hopkins*, 118 U.S. 356.

The impact of this invalid delegation of authority is to create a classification of hospitals which serves no legitimate state purpose, and which has the practical effect of denying abortion services to a significant number of poor persons in Georgia, denying to the poor the equal protection of the laws under the Fourteenth Amendment.

We have already discussed the lack of a rational connection between any legitimate state purpose concerned with the quality and integrity of a hospital facility in the performance of abortion and the JCAH accreditation requirement. Granting the legitimacy of such a state concern, it cannot be accomplished through an unconstitutional and arbitrary means (the unreviewable delegation to JCAH), particularly when it might be accomplished properly, as through state licensing with articulated or legislatively reviewable standards. *Yick Wo v. Hopkins, supra*; *McGautha v. California, supra* (Brennan, J., dissenting); See also *NAACP v. Alabama*, 377 U.S. 288; *Thornhill v. Alabama*, 310 U.S. 88.

There would seem to be no legitimate state purpose served in cutting down the number of abortions by limiting the hospitals in which they can be performed (83

of 214 licensed hospitals, *supra*), in that the concern here is with abortions which are otherwise legal under state law. There is obviously no legitimate purpose served in prohibiting that which is lawful.

There are no state economic, or budget-saving purposes served in the accreditation requirement *per se*, and there is no demonstrable connection between this classification and a rational allocation of state resources. *See Dandridge v. Williams*, 397 U.S. 471.

On the other hand, the practical discriminatory effect of this irrational classification on the poor is clear. A poor woman who resides in one of 103 Georgia counties without a JCAH accredited hospital, but which may have a ready, willing and able state-licensed hospital, and who qualifies for an abortion according to law, bears a double burden. She must not only obtain the funds necessary to travel to another county, she must also find another accredited hospital, able and willing to perform the service free or through a publicly-subsidized program.

Even though the accreditation statute has no facial discriminatory intent as to the poor, its practical effect must be measured. *Yick Wo v. Hopkins*, *supra*. Proper and lawful medical care must be viewed as fundamental to the right to life. Where access to proper and lawful medical care is conditioned by the state by creation of a classification, serving no legitimate or rational state purpose, which has the effect of denying that care to a particular group such as the poor, the effect of that classification is to deny equal protection of the laws to the poor. *See Shapiro v. Thompson*, 394 U.S. 618; *Harper v. Virginia Bd. of Elections*, 383 U.S. 663; *Griffin v. Illinois*, 351 U.S. 12.

B. Delegation of Authority to Physicians and Their Committees to Approve Abortions at Their Peril Results in Discrimination Against the Poor and the Non-White.

The Georgia legislature has created certain protected classes of women who may receive legal abortion: those who would suffer life or permanent health threatening consequences, those who are likely to bear defective children, or those who have been the victims of sexual assault. §26-1202(a), Ga. Code Ann. The court below struck down the specification of these classes but retained the general classification of women for whom abortion is deemed "necessary". *See Appellant's Jurisdictional Statement herein, App. F, p. 1-f.*

The legislature has then delegated its authority to determine who falls into these classes, and under what circumstances, to physicians and hospital committees made up of physicians. Two physicians other than the woman's own must concur in the finding, and this concurrence must in turn be approved by a committee of at least three additional physicians in the accredited hospital which is to perform the abortion. §26-1202(b) (3) and (5). This statutory procedure was not invalidated by the court below.

Abortion is otherwise criminal in Georgia, punishable by a one to ten year prison term. §§26-1201, 26-1203, Ga. Code Ann.

Abortions performed outside of the Georgia abortion law (§26-1201 *et seq.*) or performed in error under the statute are criminal abortions. Physicians may clearly be prosecuted even though excepted under the statute, since a prosecutor and jury may not agree with the physician as to the "necessity" of the abortion or the

presence of the life or health-threatening conditions or other circumstances specified in the law. The burden of going forward with the evidence to prove non-necessity may be on the prosecution, but the decisions of physicians are not immune from prosecution. *See U.S. v. Vuitch*, U.S., 91 S. Ct. 1294, 1298; but cf. *U.S. v. Vuitch*, 91 S. Ct. 1294, 1311-12 (Stewart, J., dissenting in part).

The Georgia legislature has assigned to these physicians the task of determining whether a woman falls into one of the specified categories at their peril. The court below did not eliminate the peril, but merely limited the category for decision to the word "necessary." In either case, a prosecutor may choose to disagree with the determination in favor of the woman, and a "second-guessing lay jury" may choose to convict. *See U.S. v. Vuitch, supra*, 91 S. Ct. at 1312 (Stewart, J., dissenting in part).

It must be noted here that so long as this second-guessing of medical judgment is permitted, the mere existence of a moral temper adverse to abortion in the prosecutor's office or in the community may have a heavy influence on the making of that judgment. The majority in *Vuitch* suggest that this "danger exists in all criminal cases, not merely those involving abortions." *U.S. v. Vuitch, supra*, 91 S. Ct. at 1299, n. 7. This is not so. In virtually all criminal cases the factual issue for the jury to decide is whether or not the defendant committed the criminal act charged, the act and the crime being one and the same. In abortion cases, com-

mission of the act of abortion by the physician, or its abetment by the committee, may be conceded. The criminality of the act under the statute is, in every case, a matter of qualitative judgment. This is not to say that *voir dire* of jurors and the watchfulness of judges does not help blunt the danger (*U.S. v. Vuitch, id.*) but it does point up the danger to physicians in a hostile environment when it is not their commission or abetment of the act which may be criminal, but the quality of their expert judgment. This "danger" does not exist in all criminal cases. Mr. Justice Clark has added:

... [D]octors face an uncertain fate when performing an abortion. This uncertainty will continue unless the legislatures or courts provide relief from liability. Clark, "Religion, Morality and Abortion: A Constitutional Appraisal", 2 *Loy. U. (L.A.) L. Rev.* 1, 7 (1969).

On the other hand, no prosecution or penalty exists for physicians who decide that the woman is not qualified for an abortion. In considering the slanted consequences of this kind of legislative delegation, the California Supreme Court, in that state's landmark abortion case, said:

The inevitable effect of such delegation may be to deprive a woman of an abortion when under any definition [of the statutory categories] she would be entitled to such an operation, because the state, in delegating the power to decide when an abortion is necessary, has skewed the penalties in one direction: *no* criminal penalties are imposed where the doctor refuses to perform a necessary operation, even if the woman should in fact

die. . . . The pressures on a physician to decide not to perform an absolutely necessary abortion are . . . enormous. . . . *People v. Belous, supra* at 973.

Amici do not suggest that every physician faced with the possibility of prosecution, and with having his own medical judgment subjected to lay public review, cannot nevertheless render a fair decision on the merits of an application for abortion. But the risk to be run that the average physician will not be able "to hold the balance nice, clear and true" is substantial, and its impact on Due Process plain. *Tumey v. Ohio*, 273 U.S. 510, 532. This kind of risk of a skewed decision by a personally interested decision-maker has regularly been held to be an invalid delegation of authority. *See In re v. Murchison*, 349 U.S. 133; *Mayberry v. Pennsylvania*, 400 U.S. 455; *Jackson v. Denno*, 378 U.S. 368; *Tumey v. Ohio, supra*.

Furthermore, the decision-making process under this delegation of authority has all the aspects of a star chamber proceeding. Time is obviously of the essence in considering an application for abortion, and there is no appeal from an abortion committee's decision. The decision is made in private, with no provision for personal appearance by the applicant. And in this situation, the question to be decided may be one of life or death, the most fundamental of all human rights.

Where a poor, non-white woman is in need of abortion, the delegation of this authority results in a denial of equal protection, because the poor woman is re-

stricted by her economic circumstances to seeking abortion in an accredited hospital willing or otherwise obliged to treat indigents. Nothing in the law or in common medical practice prevents the affluent woman from consulting with any physician and going to any accredited hospital most likely to provide the desired treatment. The denial of abortion to a poor woman under these circumstances has the effect of a decision *res judicata*. The more affluent woman may shop among hospitals and doctors until she finds those who will favor her application, even if it has been rejected elsewhere.

The most disastrous result of the abortion committee system has been the economic and social discrimination against one group—the ward patients. In large cities the poor . . . are virtually denied the same medical care as the privileged few. Lader, *Abortion* 29-30 (1966).

The abortion practices of hospitals treating the poor, as compared with the same practices respecting the affluent (Part II, *supra*), reflect the discriminatory result of this delegation of authority. Thus, in effect, a denial of equal protection results when a statute conferring a right to an abortion upon certain kinds of women operates to confer decision-making authority as to the affluent upon numerous abortion-providers, but in effect results in limiting decision-making authority as to the poor to one (or none) or a very few lawful abortion providers with substantial and compelling interests impairing their ability to decide impartially whether a woman is entitled to an abortion.

IV.

GEORGIA'S STATUTORY OPTION FOR HOSPITALS TO REJECT ABORTION PATIENTS, TO THE EXTENT IT IS EXERCISED BY PUBLIC OR PUBLICLY-SUBSIDIZED HOSPITALS, SANCTIONED A DENIAL OF EQUAL PROTECTION TO THE CLASS OF PATIENTS REQUIRING ABORTION, HAVING A PARTICULARLY SEVERE IMPACT ON THE POOR AND NON-WHITE.

§26-1202(e), Ga. Code Ann., permits hospitals to elect to refuse patients seeking abortion services.

Appellants and *amici* have no quarrel with the notion that individual physicians with religious or moral objections may choose not to perform abortions. *See* Appellant's Jurisdictional Statement herein, p. 22. Hospitals, however, are fictitious entities, without religious or moral scruples *per se*. Indeed, the statute does not suggest religious or moral reasons as the standard for hospitals in exercising this option; the statute permits its exercise at whim.

Hospitals which are publicly owned or operated, which are recipients of Hill-Burton federal construction subsidies (42 U.S.C. 291 *et seq.*), or which participate in the federal Medicaid program and receive federal Medicaid funds (42 U.S.C. 1396 *et seq.*) have sufficient public nexus to be engaged in state action, prohibiting them from denying equal protection of the law to irrationally selected classes of persons. When these particular kinds of hospitals choose to deny services to a class of patients, the impact on the poor is clear, since publicly owned hospitals largely serve the poor, Hill-Burton hospitals have a statutory obligation to provide service to the poor (42 U.S.C. 291c(e)) and

Medicaid funds are devoted exclusively to welfare recipients or the medically indigent related to welfare categories (42 U.S.C. 1396).

Hospitals which have received Hill-Burton subsidies have been held to be bound by constitutional equal protection requirements. The same public nexus analysis would seem to apply to publicly owned hospitals and those receiving federal Medicaid funds. See *Simkins v. Moses H. Cone Memorial Hosp.*, 323 F. 2d 959 (4th Cir. 1963), cert. denied, 376 U.S. 938; *Sams v. Ohio Valley Gen'l Hosp. Assn.*, 413 F. 2d 826 (4th Cir. 1969).¹

Simkins involved refusing admission of black doctors and their patients to Hill-Burton funded private hospitals. It was held that this amounted to state action in violation of the equal protection clause. The finding was perhaps made easier because the inherently suspect classification of race was present. In *Sams*, however, there was no inherently suspect class, but merely a refusal by the Hill-Burton funded private hospital to grant staff privileges to doctors whose offices were located outside the county. Relying solely on the test of a rational basis for the classification (see e.g., *Dandridge v. Williams, supra*) the court could find none. The court gave particular weight to the consequences of the policy for a patient living in the county being denied hospital service because his physician's office was across the county line. 413 F. 2d at 829.

The impact of the state-sanctioned policy under consideration here, to turn away the class of patients who require abortion service, is similar. Where those patients

¹There are more than 190 Hill-Burton funded hospitals in Georgia, which is about 75% of all its licensed hospitals. See U.S. Dep't of HEW, *Hill-Burton Project Register* 80-92 (1969).

are poor, it will have the tragic consequence of denying them any treatment at all. Where a public, a Medicaid or a Hill-Burton hospital, which otherwise cares for the poor and is capable of rendering abortion services (e.g., by having an obstetrical staff, etc.), and which is the only conveniently located licensed and accredited hospital for an indigent who legally qualifies for an abortion, and who has a ready, willing and able staff physician to perform it, chooses to reject all abortion patients as a class, then that indigent abortion patient is denied equal protection of the law.

There is no legitimate state purpose served in sanctioning an elimination of abortion services in such a hospital. One state purpose might be to cut down the number of abortions. But where state law permits abortion, and where the patient is eligible for the service under state law, there would seem to be no legitimate state purpose served in denying her the treatment.

Another such purpose might be to save state funds, to the extent they are involved in supporting a public hospital, or in the state matching funds under Medicaid (42 U.S.C. 1396a(a)(2)). But state budget-saving is not a legitimate state purpose when the class to suffer the deprivation of the state funds is arbitrarily and unreasonably selected. *See Shapiro v. Thompson, supra.*

Another such purpose might be religious or moral objection to abortion. But no such standard is articulated in the statute, perhaps in recognition of the fact that hospitals cannot, as fictitious entities, have religious or moral scruples. Without such an articulated standard, however, the statute clearly permits public, Hill-Burton and Medicaid hospitals to exclude abortion patients for any reason at all, which would seem

clearly offensive to the constitutional responsibilities of those hospitals. Thus, abortion patients might be excluded from an otherwise nonsectarian public or publicly-subsidized hospital solely because of the religious objections of the current administrator, or medical director, or the currently sitting majority of the board of directors.

The state may assert that it has not dictated the elimination of abortion services, but has only permitted hospitals to choose not to render them. The issue here is not what the rights of the parties might be were the state law silent on this subject, and an individual hospital decided to discriminate against abortion patients. The issue here takes for granted the legality of abortion in Georgia, at least under specified circumstances, and the state's permission under express color of law for hospitals to turn away this class of patients. The state should not be allowed to expressly permit by law an arbitrary discrimination against a class, without a legitimate state purpose, where it could not compel the same. *See Griffin v. County School Board of Prince Edward County*, 377 U.S. 218 (state law permitted, by local option, the closing of schools, where purpose was to discriminate against the class of Negro students); *Reitman v. Mulkey*, 387 U.S. 369 (state law permitted the conveying of property to anyone the conveyor might choose, where the purpose was to authorize discrimination in housing).

It may be contended that this statutory provision of "choice" to exclude abortion patients and thus to effectively deny treatment to the poor and non-white is more closely analogous to the situation in *James v. Valtierra*, U.S., 91 S. Ct. 1331, where man-

datory referenda for low-cost housing projects were upheld against a claim that they permitted voters to discriminate against the poor. But the Court, in *James*, placed heavy reliance on the procedure there involved (a "democratic" election) and on the legitimate public purposes served thereby (giving the people a voice in approving huge expenditures of public funds and a consequent lowering of tax revenues, and a voice in general community planning). 91 S. Ct. at 1334. Here, as mentioned, the only procedure provided is the whim of the hospital, and there is no such legitimate state purpose served in excluding these patients.

V.

CONCLUSION.

The equal protection infirmity of a statute whose burden is felt more acutely by the poor has been noted in Mr. Justice White's concurring opinion in *Griswold v. Connecticut, supra* at 503:

[T]he clear effect of these statutes as enforced is to deny disadvantaged citizens of Connecticut, those without either adequate knowledge or resources to obtain private counseling, access to medical assistance and up-to-date information in respect to proper methods of birth control. . . . In my view, a statute with these effects bears a substantial burden of justification when attacked under the Fourteenth Amendment. *Yick Wo v. Hopkins*, 118 U.S. 356; *Skinner v. Oklahoma*, 316 U.S. 535; *Schware v. Board of Bar Examiners*, 353 U.S. 232; *McLaughlin v. Florida*, 379 U.S. 184, 192.

Because this Georgia statute, like all restrictive abortion laws, has the clear effect of denying poor and non-white citizens of Georgia equal access to safe hospital abortions without any justification whatsoever, it violates the Equal Protection Clause of the Fourteenth Amendment.

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